SPECIAL NUTRITION PROGRAMS CERTIFICATE OF AUTHORITY

(PRINT NAME OF AUTHORIZED PERSON)

(SIGNATURE OF AUTHORIZED PERSON)

IS DESIGNATED AS THE AUTHORIZED REPRESENTATIVE OF THE

(NAME OF INSTITUTION)

(STREET ADDRESS)

Authority is hereby given to the above designated representative to enter into an agreement whether by handwritten or electronic signature, on behalf of the above-named institution for the operation of the Child and Adult Care Food Program, National School Lunch Program, and/or Summer Food Service Program, on all remaining forms for this application and any other documents or Division reports relating thereto, including claims for reimbursement.

PLEASE SUBMIT ONE (1) FORM PER PERSON WITH SIGNATURE AUTHORITY

Non-Profit Institution

BY:		
(Signature)	(Title)	(Date)
For-Profit Institution (CACFP Only	<u>)</u>	
BY:	/	
(Signature: OWNER(S))		(Date)
personnel and my designation of the above	Special Nutrition Programs must be advised immediately e-named representative does not relieve me of any liability d representative in the name of or on behalf of the above-	y for the mistakes, fraud or any other
(If interested in Direct Deposit, please call the SNP C	office at 501.682.8869 or 1.800.482.5850 ext. 28869)	
On-line Password Request(s)	Will this person be submitting claims? YES	$S \square NO \square$
	Will this person need access to application?	YES 🗆 NO 🗆
Name:Last First	Last 4 of SSN:	
E-Mail Address:		
Answer one (ONLY ONE) of the fol		
	iowing security questions.	
What is your mother's maiden name?		
What was your first pet's name?		
What city were you born in?		
What is your favorite color?		
(SNP-2)		

Agreement #: _____

(TITLE)

(TELEPHONE NUMBER)

This is to certify that _____

J

(CITY, STATE, ZIP)